

# Implementation Collaborative

## Patient- and Family-Centered Care 2008 Field Brief

### BENCHMARKING & IMPROVEMENT SERVICES

#### IMPROVEMENT INITIATIVES

Implementing Core Concepts

Working With Patient  
and Family Advisers

Measuring Performance



THE POWER OF COLLABORATION

## Patient- and Family-Centered Care Implementation Collaborative Participants

Harborview Medical Center  
The Johns Hopkins Hospital  
MCG Health, Inc.  
NYU Langone Medical Center  
The Ohio State University Medical Center  
Shands Jacksonville  
UC Irvine Medical Center  
University Hospital of the SUNY Upstate Medical University  
University Medical Center of Southern Nevada  
University of Colorado Hospital  
University of Iowa Hospitals and Clinics  
University of Maryland Medical System  
(University of Maryland Medical Center)  
University of Minnesota Medical Center, Fairview  
University of Pennsylvania Health System  
(Hospital of the University of Pennsylvania)  
University of Washington Medical Center  
UNM Hospitals  
Vanderbilt University Medical Center  
Wishard Health Services  
Yale-New Haven Hospital

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For links to the materials from UHC's Patient- and Family-Centered Care projects, including member presentations and Web conference recordings, the benchmarking project field book, survey results, and innovative strategies, log in to the UHC Web site at [www.uhc.edu](http://www.uhc.edu) and go to the Benchmarking & Improvement Services area.

For more information about UHC's Patient- and Family-Centered Care initiatives or to be added to the listserver, contact the project manager, Kathy Vermoch, at 630/954-1030 or [vermoch@uhc.edu](mailto:vermoch@uhc.edu).



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# Introduction to the Collaborative

## What Is Patient- and Family-Centered Care?

The Institute for Family-Centered Care (IFCC) defines *patient- and family-centered care* (PFCC) as “an innovative approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among health care patients, families, and providers.”

The core concepts of PFCC, according to the IFCC, are:

- “Dignity and respect: Health care practitioners listen to and honor patient and family perspectives and choices. Patient and family knowledge, values, beliefs, and cultural backgrounds are incorporated into the planning and delivery of care.
- “Information sharing: Health care practitioners communicate and share complete and unbiased information with patients and families in ways that are affirming and useful. Patients and families receive timely, complete, and accurate information in order to effectively participate in care and decision-making.
- “Participation: Patients and families are encouraged and supported in participating in care and decision-making at the level they choose.
- “Collaboration: Patients, families, health care practitioners, and leaders collaborate in policy and program development, implementation, and evaluation; in health care facility design; and in professional education, as well as in the delivery of care.”

## About the Implementation Collaborative

The UHC Patient- and Family-Centered Care Implementation Collaborative was formed because the findings of the Patient- and Family-Centered Care 2007 Benchmarking Project identified many opportunities for UHC members to increase patients’ and families’ participation in their care, including opportunities to:

- Improve two-way communications between providers and patients/families
- Work effectively with patient/family advisory councils
- Measure performance and evaluate the impact of PFCC improvement initiatives

Between June and November 2007, 19 organizations took part in PFCC Implementation Collaborative activities, including 6 monthly conference calls. Before the first call, participants identified team members, strategies for implementation, and performance measures, and completed an implementation worksheet including a gap analysis.

During the first call, participants discussed challenges, goals, and strategies. During calls 2 through 5, participants presented progress reports, engaged in group problem solving, and exchanged tips, tools, and advice. The sixth call wrapped up the project with discussion of conclusions and future plans. After the collaborative concluded, teams continued to work toward goals and to network with colleagues via the PFCC listserver.

Examples of initiatives undertaken by collaborative participants are summarized in Figure 1.

## Rationale for the Implementation Collaborative

The major organizational changes often needed to address significant issues can be overwhelming, and UHC members sometimes need assistance during the early stages of change implementation. For this reason, UHC follows up major operational benchmarking projects by offering implementation collaboratives to help members begin the change process.

Collaborative participants design their own improvement initiatives, using project data or internal data when appropriate; participation in the original benchmarking project is not required.



### Patient- and Family-Centered Care Benchmarking Resources

A number of resources from UHC's Patient- and Family-Centered Care projects are available; log in to the UHC Web site at [www.uhc.edu](http://www.uhc.edu) and go to the Benchmarking & Improvement Services area. Available resources include:

- Benchmarking project field book
- Action plan
- Knowledge transfer meeting presentations and Web conference recordings
- Innovative strategy reports
- Detailed survey results
- PFCC listserver
- Sample Performance Opportunity Summary and Scorecard

PFCC Implementation Collaborative Initiatives <sup>a</sup>	
Initiative	Organization(s) Implementing Initiative
<b>Implementing PFCC Core Concepts</b>	
Launch a large-scale pilot test of family activation of the rapid response team	Shands Jacksonville
Develop education and training materials for family activation of the rapid response team	Yale
Prepare to implement bedside medical or nursing rounds	NYU, Vanderbilt, UPenn, Iowa
Pilot test the use of liaisons in the emergency department to improve communications between staff and patients/families	UPenn
Design a pilot test for open (24/7) visitation in the coronary care unit	NYU
Identify opportunities and implement practices to increase the value and use of the MyHealth@Vandy patient portal	Vanderbilt
Implement newborn "well-baby checks" performed in the mother's room in the presence of the parents	MCG
Develop a plan for family presence during resuscitation	Ohio State
Work with patient and family services to improve communications with families in the surgical centers	Nevada
Survey families to improve satisfaction with critical care services	Harborview
<b>Working Effectively With Patient/Family Advisory Councils</b>	
Implement an outpatient advisory council	Ohio State, NYU
Improve or establish effective patient/family advisory councils	Fairview, Upstate, Harborview, Wishard, UNM, UC Irvine
Design patient and family educational materials with adviser input	Maryland, Upstate
Recruit new advisers and improve the effectiveness of advisory councils	Colorado, Fairview
Establish a neonatal family action team and successfully implement family participation in medical rounds in the pediatric intensive care unit	UC Irvine
Work with advisers to plan the renovation of a patient care unit	Wishard
Recruit advisers and draft a charter for a cardiovascular patient/family advisory council	Maryland
Create an award to recognize individuals and teams that demonstrate PFCC concepts	Colorado
<b>Measuring Performance and Evaluating the Impact of PFCC Improvement Initiatives</b>	
Analyze Press Ganey and HCAHPS satisfaction data to track and trend PFCC performance by unit	Upstate
Measure outcomes of PFCC initiatives	Washington
Revise job descriptions and evaluations in rehab services to include PFCC concepts	Washington
<b>Implementing Organizational PFCC Initiatives</b>	
Conduct an organizational assessment to identify PFCC improvement opportunities	Hopkins
Develop an organizational PFCC implementation plan	Nevada
Develop a curriculum to teach nursing staff about PFCC concepts and practices	UNM

Figure 1 – Source: UHC Patient- and Family-Centered Care Implementation Collaborative

<sup>a</sup>This list of implementation collaborative initiatives is not comprehensive.

HCAHPS = Hospital Consumer Assessment of Healthcare Providers and Systems; PFCC = patient- and family-centered care.

# Successful Strategies

## Implementing PFCC Concepts

To hardwire change in the organization, the University Hospital of the SUNY Upstate Medical University (Upstate) educated staff about PFCC and completed organizational and patient/family satisfaction assessments. Upstate also established standards, developed guiding principles for the hospital, and applied those principles to everyday practice and decision making. (Outcomes of Upstate's PFCC performance measurement initiatives are described in the "Successful Strategies" section under "Measuring Performance.")

Focusing first on hospital leadership and management, the staff education effort integrated "sharing stories" and opportunities to have fun while communicating important messages. For example, leaders and managers played "PFCC Jeopardy," created humorous top-10 lists, and viewed the *Strategies for Leadership* video from the IFCC. Upstate dedicated an intranet site to the staff education effort and provided evidence-based literature demonstrating the effectiveness of PFCC to staff.

Organizational and family assessments modified from an IFCC tool were essential to the staff education effort because of the perspective they provided. Completed in 25 inpatient and 27 outpatient areas, as well as in all specialty and ancillary service areas, the organizational assessment survey measured the staff's perceptions of performance on core PFCC behaviors.

The patient/family assessment then enabled Upstate to compare the perceptions of patients and families with those of staff. The comparison showed that while opportunities for improvement existed, hospital staff often rated themselves lower than did patients and families on core behaviors such as introducing themselves and explaining their roles in the care of the patient.

The organizational and patient/family surveys also measured perceptions of patient/family participation, collaboration/communication, and the 3 C's (choice, communication, collaboration), which are the primary ideas behind Upstate's "circle of influence" (Figure 2).

**Patient- and Family-Centered Care Circle of Influence**

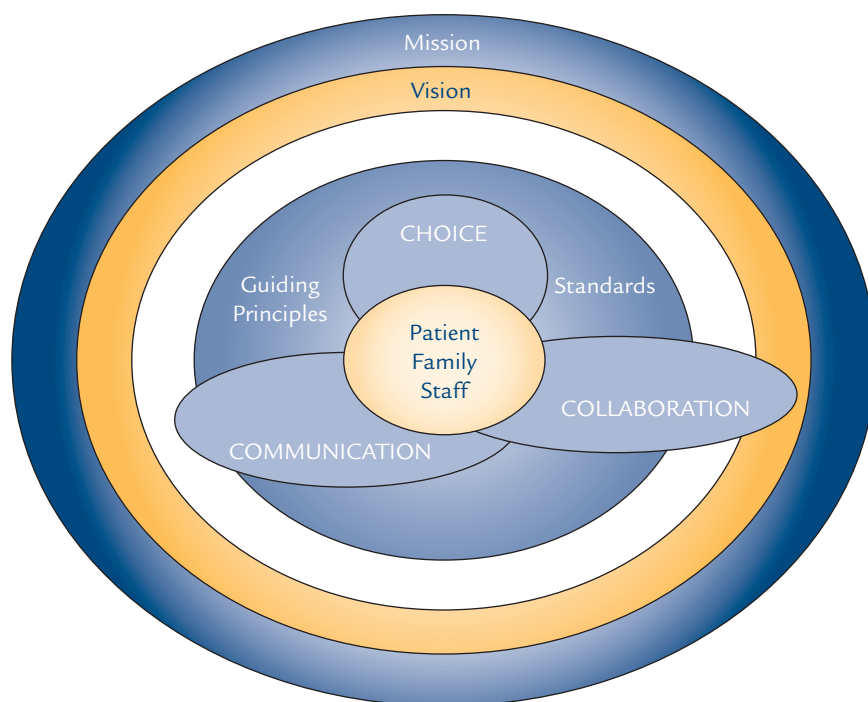


Figure 2 – Source: Rodgers L, Legault J; University Hospital of the SUNY Upstate Medical University. A service initiative—hardwiring for organizational change at University Hospital. Presented at: UHC Patient- and Family-Centered Care Implementation Collaborative Web Conference; January 23, 2008.

The 3 C's ask 3 important questions:

- Have I given the patient and family a choice?
- Have I communicated the information the patient and family need to make a decision?
- Have I partnered or collaborated with the patient and family to meet their needs?

Using the findings of the assessment surveys, Upstate identified strengths and areas for improvement. The organization also determined to maintain focus on ensuring consistent performance on core behaviors.

Through this process, Upstate developed these PFCC guiding principles:

- Patient- and family-centered care is a philosophy of care and service to health care that shapes policies, programs, system changes, facility design, and day-to-day interactions among staff.
- Patient- and family-centered care is an approach to health care delivery that redefines the relationships between the customer and health care providers.
- Information sharing and collaboration among patients, families, and staff are cornerstones of this approach to care.

Upstate also developed standards in 3 major areas: policies and procedures, facility, and human resources.

The policies and procedures standards include using friendly language in all policies and documents designed for patients and families,

*To hardwire PFCC principles and standards into the culture, Upstate incorporated them into the organization's strategic plan.*

patient/family adviser review of all patient education materials for content and ease of reading, and completion

of a standards form to ensure that any new or revised policies or procedures are consistent with PFCC principles.

Standards for the facility include making sure that the environment conveys a sense of healing and caring, makes a positive first impression, and meets the needs of providers, patients, and family members.

Human resources standards require the annual employee evaluation process to incorporate the organization's customer service standards, which are sent to all employees.

To hardwire PFCC principles and standards into the culture, Upstate incorporated them into the organization's strategic plan, with the endorsement of the president. Five major teams—clinical enterprise, students, faculty, research, and employer of choice—worked to implement major PFCC components. The teams focused on establishing a “patient first” philosophy, a physical and operational environment that ensures easy and timely access to care, means to identify and provide aid for patients who need financial assistance, a “mystery shopper” program that uses advisers to report on their experiences in the health center, and institution-wide service standards for phone management, referrals, and consultations.

**The Johns Hopkins Hospital encouraged the active involvement of patients and their families as a patient safety strategy.** As part of the JHH Patient Safety Strategic Plan, the JHH Patient Safety Committee was tasked to engage patients and families as partners and to create opportunities to involve them in safety initiatives. The committee's goal was to find a PFCC “sweet spot” by crossing the traditional silos of safety, service, and quality (Figure 3). Through this process, Hopkins educated patients and families on how and when to report concerns about care, treatment, services, and patient safety issues.

Various communication techniques were implemented, including a patient safety video (which can be viewed at [www.hopkinshospital.org/patients/patient\\_safety.html](http://www.hopkinshospital.org/patients/patient_safety.html)) for patients and families. The video emphasizes the idea of a health care partnership between patients, families, and providers. It acknowledges that large medical centers can be intimidating and encourages patients to ask questions and speak up. The importance of such things as giving accurate information to care providers, ID bracelets, and hand washing is explained and emphasized, and information on avoiding various safety issues, such as falls, is offered.

Other task force recommendations included the “Pathway to Partnership Pledge” (Figure 4), unit orientations including the pledge, plasma screen messages, and unit surveys on patient safety strategies. The task force also assessed the feasibility of message boards.

### The PFCC “Sweet Spot”

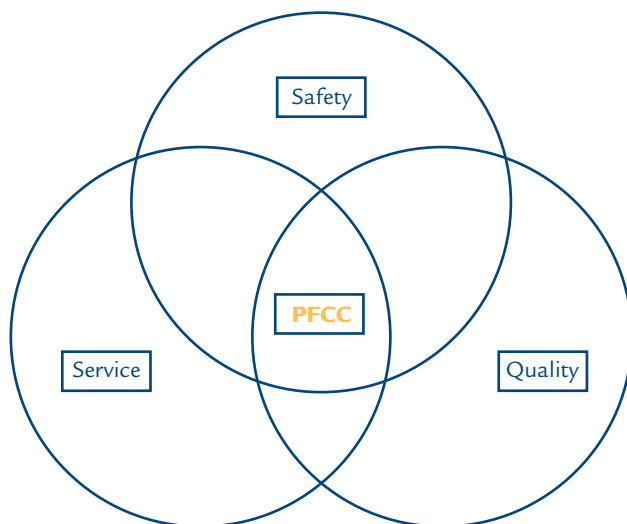


Figure 3 – Source: Paine L; *The Johns Hopkins Hospital. Patient and family involvement: a patient safety strategy*. Presented at: UHC 2007 Quality and Safety Fall Forum; Palm Desert, CA; October 11-12, 2007.

### The Johns Hopkins Hospital “Pathway to Partnership Pledge”

## Our Partnership Pledge

At Hopkins, we take a team approach to your safety.  
We invite you and your family to join us as active  
members of your care team.

#### We pledge to

- Coordinate your care
- Explain your care and treatment
- Listen to your questions or concerns
- Ask if you have safety concerns and take steps to address them
- Ask about your pain often and keep you as comfortable as possible
- Check your identification before any medication, treatment or procedure
- Label all lab samples in your presence
- Clean our hands often

#### We ask you, or a loved one, to

- Ask questions
- Speak up if you are concerned about a test, procedure or medicine
- Check the information on your ID bracelet for accuracy
- Be clear and complete about your medical history, including current medications
- Clean your hands often and remind your visitors to do the same
- Remind us if we do not carry out our pledge to you

We welcome your involvement and feedback. The unit manager is available to hear concerns about your care and safety.

*From the doctors, nurses and staff of The Johns Hopkins Hospital*

Figure 4 – Source: Paine L; *The Johns Hopkins Hospital. Patient and family involvement: a patient safety strategy*. Presented at: UHC 2007 Quality and Safety Fall Forum; Palm Desert, CA; October 11-12, 2007.

Hopkins' future plans include finishing an organizational strategic plan for patient- and family-centered care implementation, creating patient and family advisory councils, and developing forums to share internal best practices.

**Developing a culture where providers bond with patients and families as collaborators and partners was Harborview Medical Center's goal when it embarked on a hospital-wide cultural change initiative.** With leaders throughout the organization sharing responsibility for the change initiative's leadership, the culture change was viewed as a 3- to 6-year project to truly transform the way providers relate to patients and families.

Guided by the Institute for Healthcare Improvement Collaborative Model for Change and in conjunction with the UHC implementation collaborative, Harborview implemented a series of 3 learning sessions conducted at 6-month intervals. The change management model emphasized "PDSA"—i.e., plan, do, study, act—and "small tests of change" through which participants lose the fear of making mistakes and learn how to draw important lessons from their mistakes.

About 150 staff members representing every Harborview department participated. As many as 50 of these participants were managers or improvement advisers; the rest were front-line staff. The participants formed 14 teams, with about 10 individuals per team. Nine teams represented patient care services; 3, ambulatory care; and 2, support services.

The teams planned improvement projects that each addressed 1 of the initiative's 6 core components, which reflected the changes or improvements Harborview wanted to make—a welcoming physical environment, respect for patient/family values, patient/family empowerment/collaboration, coordination/integration of care, comfort and support, and access and navigation skills.

The initiative's first learning session took place in October 2006. Participants reviewed PFCC concepts and the model for change. Project and team development began, and participants listened to patient and family speakers as they

shared their stories and perspectives. At the second session in March 2007, each team gave a 3- to 5-slide progress report—a crucial, inspiring moment in the process. Lessons learned—especially about issues such as HIPAA (Health Insurance Portability and Accountability Act), safety, resilience, and perseverance—were shared, as were change management techniques, self-care methods, and negotiation skills. Patient and family speakers were again featured in this second session.

The third learning session focused on sustaining and spreading best practices, celebrating progress made, and making plans for the future. The concept "no gesture too small" was emphasized during a poignant story about a man who had a cardiac arrest while his wife was pregnant. The story illustrated the concept that during times when people are vulnerable, every gesture, negative or positive, takes on greater meaning.

Using suggestions from session participants, Harborview quickly made progress toward positive change. Comfortable chairs were ordered for patient rooms. Families began to be included in physician rounds and were given open access to the intensive care unit. Because families no longer had to telephone the unit for permission to enter, this change made intensive care a more pleasant, quieter environment. Family satisfaction with critical care was assessed and changes implemented. As a consequence of its efforts in this area, Harborview received the Family-Centered Care Award from the Society of Critical Care Medicine.

Staff closely monitored the daily experiences of patients to learn how they, their families, and the care providers were interacting. Next, Harborview began enabling families to be present at night in acute care services and during change of shift. Wireless Internet access was provided for families, and service recovery after instances of "bumped" surgery was initiated.

In addition to the change initiative, Harborview launched an advisory council including patients and family members and 3 medical staff members from every division. One of the patients/family members served as co-chair along with a hospital staff member, fulfilling the concept of shared leadership. Issues addressed by the



council included satisfaction data, especially in relation to patient handoffs, and name badges. Because patients were found to prefer having a provider's *role* rather than name highlighted on his or her name badge, "what we do is who we are" became the underlying concept. Harborview plans to add more physicians to the council, as well as patients and families with an outpatient focus and emergency department representatives.

Lessons learned by Harborview include "just say no to brochures." Harborview discovered that patients often view a brochure as a way to stop communication rather than to encourage it. Harborview also learned that it was important to connect with hospital-wide initiatives on patient safety and organizational improvement, thereby sharing resources, improvement advisers and tools, and opportunities to obtain patient feedback. Another lesson learned was QTIP—"quit taking it personally"—in other words, always react professionally. If a patient asks a lot of questions, for instance, it means the patient has a lot of questions, not that the provider cannot communicate effectively, and the provider should assume that the former explanation is true and respond accordingly.

Most importantly, Harborview defined what PFCC is and what it is not. PFCC is respect for all involved, empowering patients and their families, empowering health care workers to meet patients where they are and individualize their plans, "getting better together," promoting healthy relationships, being open to suggestions, and supporting a patient-driven family presence. PFCC is not a free-for-all, permission for unacceptable behavior, "the customer is always right," treating patients as though they are helpless, just about visiting, or responding defensively.

### Working With Patient and Family Advisers

PFCC initiatives at University of Colorado Hospital require that providers constantly ask the question, "Are we listening?" As patient adviser Cindy Anderson noted, the major obstacles between success and failure are

improving communication between providers and patients/families and "shutting up long enough to hear the others speak. . . . Are we listening? I certainly hope so."

Early PFCC initiatives at University of Colorado Hospital included forming a parent-staff advisory council in the neonatal care unit during the 1990s, introducing family presence during resuscitation in 2000, using patient and family focus groups in the design of a new hospital in 2001-2002, and launching a color-coded scrub apparel pilot when phase 1 of the replacement hospital opened in February 2004.

The purpose of the scrub initiative was to make the hospital environment less stressful to patients by helping them tell providers apart. Each patient received a welcome tent card that displayed the scrub colors worn by the various members of the care team. A survey of patients showed that the different colors helped patients and families identify staff roles and that having that ability to identify staff was comforting.

Colorado's current goal is to ensure that there is patient and family input into every committee at every level in the organization. Colorado established its Patient and Family Advisory Council, which also includes employees, as a step toward achieving this goal. Because the council wants the trust and cooperation of both staff and patients and families, it serves strictly in an advisory role, not as a watchdog.

One former heart transplant patient, Carl Miller, was recommended to serve on the council by 2 surgical intensive care unit nurses who cared for him. He became co-chair after attending a hospital-wide PFCC retreat. Under his guidance, the council created "foundations"—essential tools needed for success. These foundations include an application to become a family adviser and a redefined job description for family advisers, who report to Volunteer Services.

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Seeking to add cultural and generational diversity to the council, Colorado actively recruits advisers using these foundations. Other foundation tools include interview questions for prospective members, such as “Why do you want to be on the council?” “Why are you qualified?” and “What do you hope to accomplish?” Each council member also receives a formal orientation on HIPAA and other important hospital issues.

Miller and another adviser, Shirley Barr, also served as patient advisers in Colorado’s PFCC research grand rounds panel, which included a physician, a nurse, a nursing assistant, and an ambulatory care clinical educator. Miller’s perspective on the importance of care providers keeping a patient focused mentally was very valuable to the panel.

A recent hospital-wide retreat was planned primarily by the patient and family advisers. At the retreat, work groups that included patients, families, staff, and physicians focused on improving billing processes, increasing patient satisfaction, and marketing the patient and family advisory council.

Miller was also very involved in the process and plan behind Colorado’s Patient- and Family-

*Listening to family members serving as guest faculty helped students at MCG personalize what patients and families go through and motivated them to study to be the best caregivers possible.*

Centered Care President’s Award, created specifically to demonstrate the organization’s commitment to PFCC principles. The award recognizes an individual or group exhibiting superior adherence to

PFCC principles. Nominations are reviewed by the council, which then makes its recommendations to the president.

Anderson, a former lung transplant patient who has been receiving pulmonary rehabilitation services for 9 years, contributed a unique perspective and ideas about ways to involve patients and families as equal partners. She participated in the University of Colorado’s Smoke-Free Taskforce, following the process all the way from focus groups to the organizational policy change that made the campus smoke-free. This gave her the opportunity to understand the bureaucracy and approval process, and her role as an adviser increased her empathy for staff.

Anderson was a co-presenter on PFCC at a statewide oncology conference. Her willingness to share her insights with providers is driven by her desire and passion to be an advocate for her fellow patients. She encourages care providers to see patients as an untapped resource and to realize that they have a vested interest in patient satisfaction. She believes that the more patients know about their conditions, the greater an asset they become to the care team.

**MCG Health, Inc., has improved patient satisfaction through its patient and family adviser programs.** Since the beginning of its focus on PFCC concepts, MCG has seen its overall facility patient satisfaction rating improve from 79.6% to 88.3% (Figure 5).

MCG’s extensive advisory network has grown significantly over the years. In 1993, MCG had 20 advisers and 1 council. Now, MCG has 170 advisers and 10 councils—4 operating at the institutional level and 6 at the program level—actively involved with its medical center, children’s medical center, physician practice group, and educational programs. In addition, various hospital and academic committees have patient and family advisers contributing to efforts focused on patient safety improvement, medication reconciliation, and curriculum development.

MCG has had excellent results using family advisers as guest faculty in academic programs. Advisers give approximately 200 presentations per year to 29 classes in the schools of medicine, nursing, and allied health services. Analysis of 1,161 student evaluations shows that on a scale of 1 (poor) to 4 (excellent), the advisers received an average score of 3.82. Students commented that the family faculty reminds them of the importance of having compassion for and an authentic relationship with a patient and of the difference between treating the patient and treating the disease. Listening to family members serving as guest faculty helped students at MCG personalize what patients and families go through and motivated them to study to be the best caregivers possible.

See the *Patient- and Family-Centered Care 2007 Benchmarking Project Field Book* for more information about PFCC at Colorado and MCG.

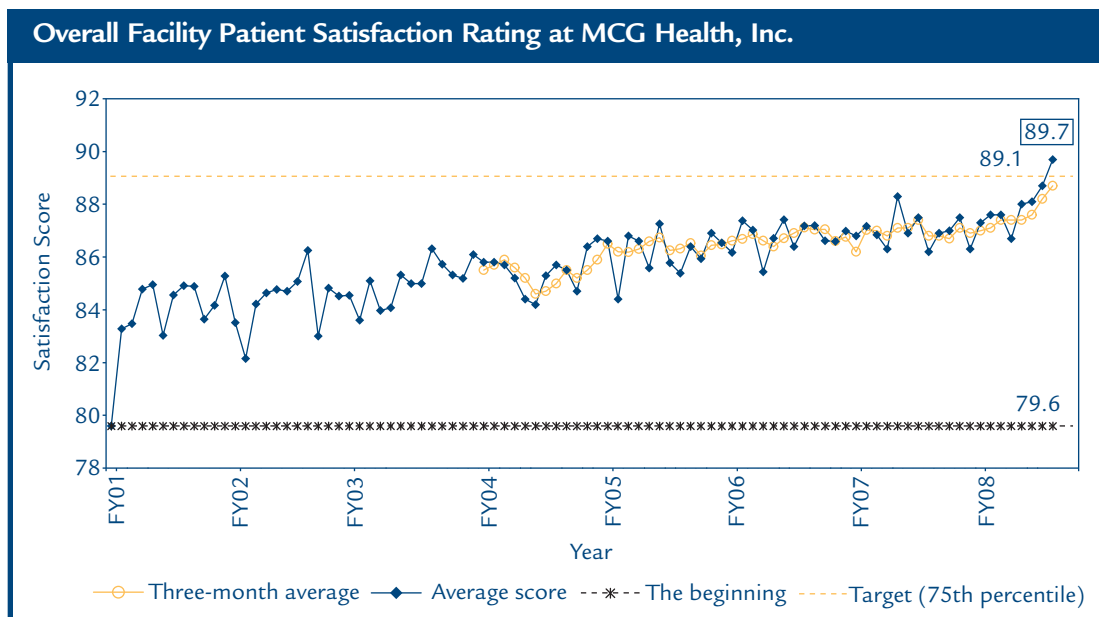


Figure 5 – Source: Sodomka P; MCG Health, Inc. Partnering with patients and families to improve outcomes. Presented at: UHC 2007 Quality and Safety Fall Forum; Palm Desert, CA; October 11-12, 2007.

## Measuring Performance

As is the case for all health care organizations, patient- and family-centered practices are becoming a more significant part of the health care quality landscape at University of Washington Medical Center. A report on patient satisfaction at Washington shows how PFCC performance contributes to quality, secures stakeholder support for partnerships with patients and families, and builds an evidence base for implementing PFCC's core concepts.

The Washington experience demonstrates the importance of creating PFCC measurement tools that are valid, reliable, and feasible. Data collected using PFCC tools must be applicable to the people who must use it to improve care and satisfaction.

Washington's measurement toolbox for PFCC includes business metrics, quality and safety measures, staff perceptions and culture, and patient and family perceptions. When designing its satisfaction measurement, Washington took the pulse of the care experience of current patients and families and found a disconnect between the dimensions of patient- and family-centered care and the existing performance measures.

To close this gap, the organization designed questions that measured practices consistent with the core concepts of PFCC. With support from Washington's PFCC Steering Committee, leaders agreed to incorporate custom questions into standard patient satisfaction surveys. To broaden stakeholder investment in the survey question design, the multiorganizational PFCC Metrics Taskforce was formed.

This task force included members from 25 health care systems from across the country. Members included patient and family advisers, Press Ganey representatives, and professionals from primary to quaternary care settings. The task force built consensus definitions and prioritized PFCC dimensions.

Small teams each designed 1 or 2 questions per dimension and brought them to the group for input and acceptance or revision. Before the questions were finalized, they were submitted to Press Ganey research for editorial revision.

*The Washington experience demonstrates the importance of creating PFCC measurement tools that are valid, reliable, and feasible.*

The task force advisers recommended 4 PFCC dimensions for measurement:

- Patients and family members feel welcomed and supported. Family members are provided with choices that respect their need-to-be-near preferences.
- Patients and families are informed of their plan of care and are given access to information to help them make decisions. Programs, supports, and services offer families good information and access to information.
- Patients and families are clear who is involved in their care and foster mutual trust and respectfully participate with providers in planning their care.
- The patients' and families' preferences are included in their plan of care. Programs, supports, and services promote family choice and control.

The task force then drilled down further to create actionable behaviors on which to base custom questions, which can be added to any Press Ganey satisfaction survey instrument, investigating 5 issues:

- How well staff explained their roles in your care
- Degree to which your choices were respected to have family members/friends with you during your care
- Degree to which you and your family were able to participate in decisions about your care
- Degree to which staff respected your family's cultural and spiritual needs
- Degree to which the staff supported your family throughout your health care experience

Analyzed in a wide variety of health care settings, the 5 questions rated very high on reliability and were closely correlated with likelihood to recommend, rating of care, and overall score for all satisfaction measures.

Four task forces are now engaging patient and family advisers in identifying specific behaviors for each question. For example, for the question regarding “how well staff explained their roles in your care,” the behaviors of “introduce yourself, explain your responsibilities, and describe your purpose” have been identified.

As the next step toward hardwiring PFCC concepts into the organizational culture and holding staff accountable for consistent performance of core behaviors, Washington is currently engaged in a pilot program to incorporate PFCC concepts into job descriptions and performance evaluations.

For more information about Washington's PFCC initiatives and performance measures, see the *Patient- and Family-Centered Care 2007 Benchmarking Project Field Book*.

**University Hospital of the SUNY Upstate Medical University provides quarterly updates showing trends in PFCC performance to the organization's leadership.** Upstate's chief executive officer communicates these reports at quarterly open forums for all staff. Celebrations are encouraged for hospital units achieving scores higher than the hospital mean.

The performance measures are organized by Upstate's 3 C's: choice, communication, and collaboration. A 2.5-year upward trend in quarterly Press Ganey satisfaction scores was noted for 2 “choice” measures—inpatient adults' likelihood of recommending hospital and overall rating of care (Figure 6).

A similar trend was noted for Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores on rating of hospital during stay, although HCAHPS scores for recommending the hospital trended slightly downward (Figure 7).



All communication and collaboration measures—deemed the most important by Upstate’s patients—trended upward. The communication measures were:

- Nurses kept patients/families informed
- Communication with nurses
- Received instructions on home care
- Physician concern for questions/worries
- Communication with doctors

Collaboration measures also trended up:

- Staff attitude toward visitors
- Being included by staff in decisions about treatment
- How well pain was controlled

Upstate’s next step is to expand measurement of PFCC performance to the nonacute care and ambulatory services.

### Trends in Patient Satisfaction Scores for 2 Press Ganey “Choice” Measures at University Hospital of the SUNY Upstate Medical University

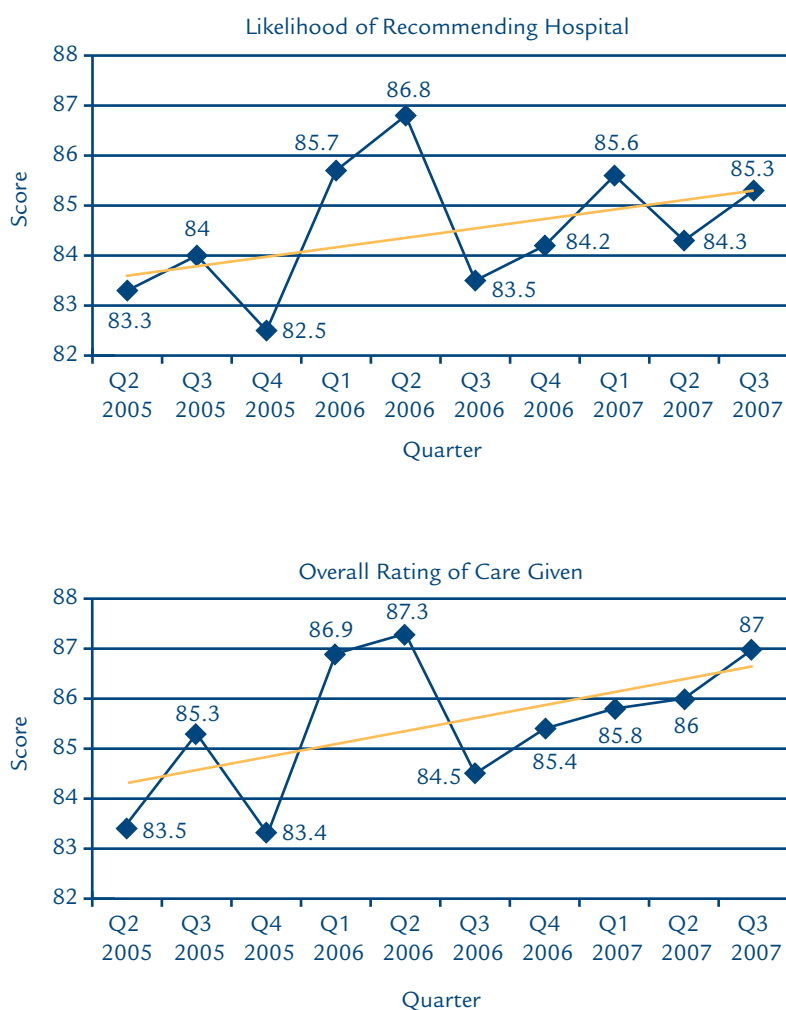


Figure 6 – Source: Rodgers L, Legault J; University Hospital of the SUNY Upstate Medical University. A service initiative—hardwiring for organizational change at University Hospital. Presented at: UHC Patient- and Family-Centered Care Implementation Collaborative Web Conference; January 23, 2008.

### Trends in Patient Satisfaction Scores for 2 HCAHPS “Choice” Measures at University Hospital of the SUNY Upstate Medical University

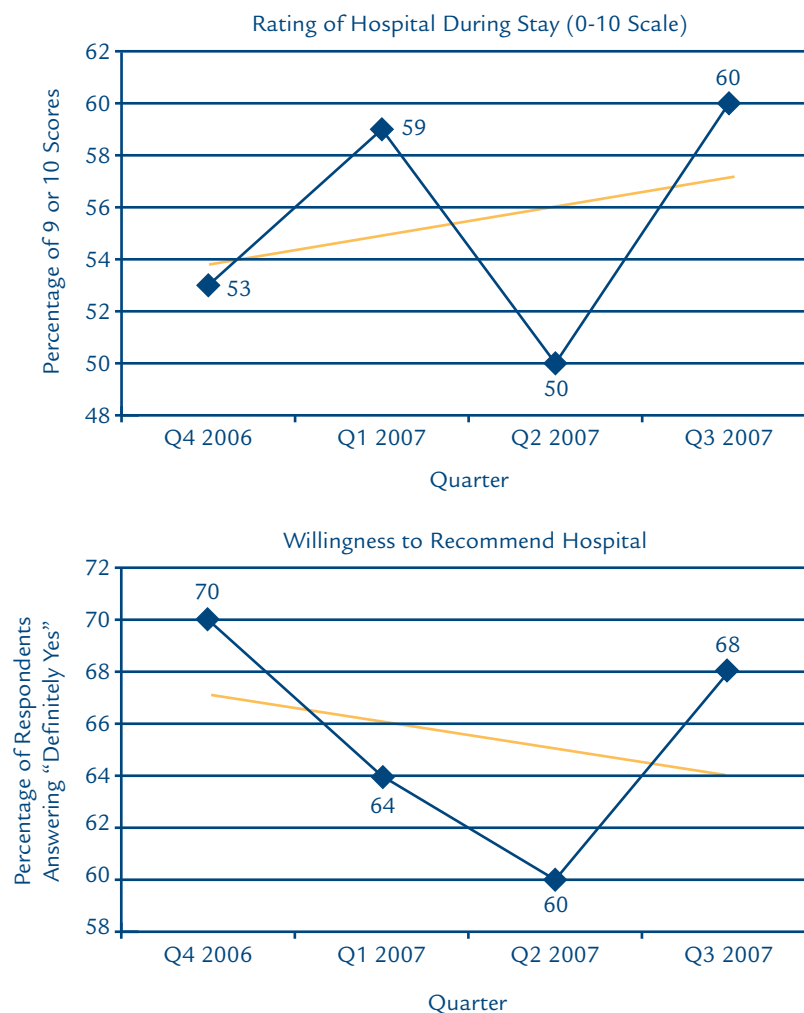


Figure 7 – Source: Rodgers L, Legault J; University Hospital of the SUNY Upstate Medical University. A service initiative—hardwiring for organizational change at University Hospital. Presented at: UHC Patient- and Family-Centered Care Implementation Collaborative Web Conference; January 23, 2008.

HCAHPS = Hospital Consumer Assessment of Healthcare Providers and Systems.

#### Patient- and Family-Centered Care Benchmarking Resources

A number of resources from UHC's Patient- and Family-Centered Care projects are available; log in to the UHC Web site at [www.uhc.edu](http://www.uhc.edu) and go to the Benchmarking & Improvement Services area. Available resources include:

- Benchmarking project field book
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- Innovative strategy reports
- Detailed survey results
- PFCC listserver
- Sample Performance Opportunity Summary and Scorecard

# Planning and Implementation Guide

This guide offers a framework for implementing PFCC concepts that takes into account the barriers and challenges encountered and the lessons learned by collaborative participants.

## Implementing Change

At the beginning of a PFCC change initiative, an organizational self-assessment of current practices helps identify and prioritize improvement opportunities. The survey tool and Performance Opportunity Summary created for the UHC benchmarking project can be used to aid in a self-assessment. A site visit to another organization that has successfully implemented PFCC concepts can also be a powerful educational opportunity. After a change initiative is launched, continuing performance assessment helps the organization gauge improvement.

Incorporating PFCC concepts into existing organization-wide initiatives relating to safety, satisfaction, and shared work governance, for example, increases buy-in for PFCC and relates it to other important organizational priorities. A study of organizational structure can help identify opportunities to establish patient/family advisers at the unit or committee level. Construction projects provide opportunities to implement PFCC concepts into units at a time when all stakeholders are involved in planning the environment and reviewing care practices.

To ensure that PFCC becomes a part of the behavior of everyone in the organization, staff and advisers must work together to hardwire PFCC concepts into the organizational culture through ongoing education about what PFCC means, including presentations by patient and family advisers; by communicating standards; by integrating PFCC responsibilities into job descriptions; and by holding staff accountable for meeting PFCC requirements in their performance evaluations.

To overcome resistance to PFCC, it may be necessary to use an incremental approach. For example, use pilot projects to test changes relating to PFCC or implement a similar but smaller-scale practice before making the intended change, such as putting family participation during nursing change-of-shift bedside rounds in place before instituting bedside medical rounds. Recruit clinical champions to demonstrate that the new practice does not take more time, and collect and share data both on staff compliance and patient and family satisfaction with the new process.

## Organizational Issues

To successfully change a culture to one that embraces the concepts of PFCC, organizations must work both from the “top down,” by informing and engaging the board and leadership, and from the “bottom up,” through staff and patient/family education. Many improvement efforts will require a good deal of work to improve communications and staff education before implementing specific PFCC initiatives. Celebrating and sharing successes is an important factor in changing the organization’s culture and implementing PFCC practices.

*Celebrating and sharing successes is an important factor in changing the organization’s culture and implementing PFCC practices.*

As organizations embark on PFCC initiatives, they cannot assume that current practices are consistent across the medical center, such as rounding procedures. Careful and complete information gathering from key stakeholders is essential before planning changes.

Success is not guaranteed after changes have been made. Significant follow-up work is required to drive and measure change. This work includes ongoing communication and education as well as surveys of staff, patients, and families.

## Leadership Success Factors

PFCC success starts at the very top and must be among the most fundamental principles guiding an organization. PFCC concepts must

*Senior leaders must model PFCC concepts and hold themselves and staff accountable for achieving and maintaining PFCC goals.*

be incorporated into the organization's mission, vision, values, philosophy, plans, safety initiatives, and scope of care. Senior leaders must model

PFCC concepts and hold themselves and staff accountable for achieving and maintaining PFCC goals.

Success requires organizational self-knowledge and measurement. Organizations must collect baseline data to obtain a clear initial picture, select and monitor performance measures to gauge progress, and collaborate with patient/family advisers on data analysis and action plans.

A paid patient and family leader position, with appropriate budget and resources, should be established; responsibilities of the position should include coordinating PFCC initiatives across the organization.

Organizations should routinely ask, "Have we gotten patient/family input on this plan?" before moving forward to interpret data or design and implement changes.

## Improving Communications

The use of simple, consistent "visual cues"—such as international symbols or color-coded name badges or scrubs—can greatly help

*Including patients and families in multidisciplinary and change-of-shift rounds improves communication and safety.*

patients and their families navigate the health care environment. Color-coded name badges and scrubs in particular can help patients and families identify

individuals on the health care team by their roles so that they know what to expect.

Because the health literacy of patients and families can never be assumed, providers and organizations should always solicit feedback on communications from both staff and patient/family advisers. Creating liaison positions can improve communications with

patients and families, especially in highly stressful environments or situations such as in emergency and critical care departments or when communicating changes in surgery schedules.

Writing or posting information on whiteboards in patient rooms can help patients and families identify caregivers, ask questions, and share important information about issues such as medications and discharge plans. Providers should be encouraged to always introduce themselves when meeting patients and family members and explain their role in the patient's care. Organizations should also consider innovative approaches to sharing information with patients and families, such as putting essential information in a weekly television guide provided for patients.

Including patients and families in multidisciplinary and change-of-shift rounds improves communication and safety, as does providing them with pens and paper during unit orientation so that they can make note of information, concerns, and questions.

Communication systems for patients, such as Web portals, must be simple to use. They should also be publicized aggressively. Making patient and family advisers available to teach their peers how to use the system will promote its use.

## Recruiting Advisers

To ensure that individuals are in the roles best suited to their personalities and talents, organizations should develop a variety of opportunities, such as council or committee participation, teaching, or focus group participation, for patients and families.

Successfully recruiting patient/family advisers requires organizations to publicize the advisory council and interview clinicians, administrators, and managers to identify potential advisers, discover opportunities for adviser participation, and increase staff and family awareness of the council's presence and value. Council appointments should be rotated, and the tenure of the appointment should be emphasized when recruiting advisers.



It is sometimes necessary to make changes to keep ideas and experiences fresh and relevant. In such cases, organizations can campaign for new members, revisit the terms of participation, recruit a new chairperson, or ask some members to resign.

Council members can encourage other patients and families to volunteer for advisory roles. Also, celebrations and the sharing of council successes can be used to help recruit new advisers.

To achieve diverse participation, meetings should be scheduled at convenient times suggested by the council. Offering transportation, child care, or other support services to advisers can help increase willingness to participate. Individuals who have valuable ideas but cannot participate directly because of health or other circumstances can be involved through e-mail, online chats, listservers, and phone conferences.

### Effective Advisory Councils

To make it clear that a patient/family advisory council is making a difference, senior leaders—including the CEO—must be actively involved with the council. These leaders must ensure that council concerns are heard and that the council is helping the organization better understand patients' and families' perspectives. For this reason, follow-up on council suggestions is essential, both when smaller changes are implemented and when progress is made on long-term initiatives. It is also important to communicate why some suggestions cannot be immediately implemented.

An adviser orientation that includes information about privacy, compliance, and confidentiality issues is critical.

If there is no patient or family member who feels ready or able to assume full leadership of the council, organizations can establish co-chairs (i.e., a patient/family member and a staff member).

When introducing a new council, call upon services that are already working successfully with advisers for help. For example, pediatric services often have experience working with advisers.

Advisers can assist in analyzing satisfaction and complaint data to find improvement opportunities and in monitoring the impact of changes.

Other good tasks for advisers include serving as “secret shoppers” to report on care experiences across the health center and developing award criteria and selecting recipients for PFCC recognition programs. Patients and families often contribute excellent suggestions for improving access, scheduling, registration, and billing procedures and for ensuring the safety of patient care handoffs.

To increase the power of their message, advisers should have ample opportunities to communicate stories and experiences directly to staff. Continually promoting the value that advisers can provide will help sustain the interest and engagement of both advisers and staff.

*Advisers can assist in analyzing satisfaction and complaint data to find improvement opportunities and in monitoring the impact of changes.*

### Measuring Performance

Success requires both organizational self-knowledge and measurement of progress. Organizations must collect baseline data to obtain a clear initial picture, select and monitor performance measures, and collaborate with patient/family advisers on data analysis and action plans.

Measurement tools must be valid, reliable, and feasible so that the data collected can be used to identify improvement opportunities and monitor ongoing performance. Measures to consider include business metrics, quality and safety measures, staff perceptions and culture, and patient and family satisfaction.

To help UHC members evaluate their own performance on patient-centered practices, selected HCAHPS measures have been added to UHC's quarterly Key Indicator Report starting with the first quarter of 2007. Below is a description of the new information included in the Key Indicator Report:

- Press Ganey patient satisfaction: overall score 0%-100%
- HCAHPS hospital rating of 9 or 10: percentage of respondents giving a 9 or 10 rating

- Question 21: Using any number from 0 to 10, where 0 is the worst hospital and 10 is the best hospital, what number would you use to rate this hospital?
- The drill-down page for this question includes the top-box responses from questions 1-3 and 5-7. Questions 1-3 evaluate nursing care (i.e., care from nurses, nurses showed courtesy and respect, nurses listened carefully and explained things in a way you could understand). Questions 5-7 assess care provided by physicians with the same focus areas.

Contact UHC's Gladys Epting at 630/954-2432 or [epting@uhc.edu](mailto:epting@uhc.edu) with questions about the Press Ganey and HCAHPS measures used in UHC performance reports.

## The Power of Collaboration

Changing organizational culture to embrace the concepts of patient- and family-centered care is a daunting task, but you do not have to do it alone. Your colleagues are available to provide information and ideas (Figure 8). UHC also sponsors a PFCC listserver for those interested in additional networking opportunities; contact the project manager, Kathy Vermoch, at 630/954-1030 or [vermoch@uhc.edu](mailto:vermoch@uhc.edu) to be added to the listserver.

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Figure 8 – Source: UHC Patient- and Family-Centered Care Implementation Collaborative

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# Important Takeaways

Patients and families are important, equal members of the care team and have the right to participate in decisions affecting the planning, delivery, and evaluation of care. Do not assume that you understand and can effectively address patient and family needs and concerns without sharing your data, asking their opinions, and involving them in creating a friendlier, more effective, efficient, and safer health care organization.

## PFCC: Not Just a Nice Thing to Do!

Blue Shield of California conducted an 18-month study of 756 HMO (health maintenance organization) members, all with late-stage illness and access to the same benefits and provider network.<sup>1</sup> Half were randomly assigned to receive usual case management and half received patient-centered management, which

included working with a care manager to develop goals based on disease state, treatment options, pain management, and end-of-life decisions. Although survival rates were the same for both groups, the study concluded that patient-centered management reduced overall costs by 26%.

Patient-centered management achieved:

- An \$18,000 cost reduction per patient
- A 38% reduction in hospital admissions
- A 36% reduction in hospital days
- A 30% reduction in emergency room visits
- A 22% increase in home care use
- A 62% increase in hospice use
- Higher satisfaction for 92% of the members receiving patient-centered management

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## The Next Step Is Yours

Through this collaborative implementation project, participants learned from the experiences of other organizations and shared information and tools that each might otherwise have had to create from scratch, increasing the lag time between identification of an improvement need and implementation of a process change.

Organizations are encouraged to continue the networking process by using the UHC PFCC listserver. Resources from the Patient- and Family-Centered Care 2007 Benchmarking Project, including the field book and action plan, can also be used to help drive change within an organization. As your efforts begin to bear fruit, please consider sharing your accomplishments with your UHC colleagues so that they can learn from your experiences.

For more information about UHC's Patient- and Family-Centered Care initiatives or to be added to the listserver, contact the project manager, Kathy Vermoch, at 630/954-1030 or [vermoch@uhc.edu](mailto:vermoch@uhc.edu).

<sup>1</sup> Sweeney L, Halpert A, Waranoff J. Patient-centered management of complex patients can reduce costs without shortening life. *Am J Manag Care*. 2007;13(2):84-92.

# Publication Summary

To find these and other resources for UHC's Patient- and Family-Centered Care initiatives, log in to the UHC Web site at [www.uhc.edu](http://www.uhc.edu) and go to the Benchmarking & Improvement Services area.

**Field Book and Action Plan**—A comprehensive summary of the most significant findings and recommendations from the 2007 benchmarking project and a detailed list of successful strategies and tactics in an action plan format to guide you in your patient- and family-centered care initiatives.

**Knowledge Transfer Meeting Presentations and Web Conference Recordings**—Project results and findings and how to use them, and presentations by the project's better performers.

**Innovative Strategies**—Specific tactics that project participants have used to improve performance.

**Survey Results**—Comprehensive reports of all data collected for the benchmarking project.

**Performance Opportunity Summary and Scorecard**—A customized report and self-assessment tool that compares each organization's performance with project benchmarks.

**Implementation Collaborative Field Brief**—A summary and discussion of the strategies employed and lessons learned by participants in the implementation collaborative.

**Compendium of Tools and Resources**—A comprehensive resource providing practical steps to patient- and family-centered care implementation.

**PFCC Listserver**—A networking resource that allows participants to share topic-related ideas, problems, and resources with professional colleagues.

## Project Manager

For more information about UHC's Patient- and Family-Centered Care initiatives or to be added to the listserver, contact the project manager, Kathy Vermoch, at 630/954-1030 or [vermoch@uhc.edu](mailto:vermoch@uhc.edu).



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